Moorland House Limited

Moorland House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Moorland House offers accommodation for up to 20 people who require personal care, including those who are living with dementia.

At our inspection in October 2015 we identified the provider was not meeting the fundamental standards in a number of areas. We issued seven requirement notices and asked the provider to make improvements to the systems in place to keep people safe from harm and to prevent unlawful restrictions on people. Consent to care was not always sought In line with current legislation and guidance. Risk assessments had not always been completed and actions were not taken to mitigate risks. Staff training and medicines management required improvement and recruitment practices were not safe. Staff were not familiar with and able to apply the principles and codes of conduct associated with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The systems in place to assess, monitor and improve the quality and safety of the service were not operated effectively and records had not been accurately maintained.

At our inspection in December 2016 we found some improvements had been made. However, some concerns were on-going and new areas of concern were also identified.

Following the inspection, we issued four enforcement notices to the provider and registered manager for their on-going failure to meet four regulations in relation to the need for consent; safeguarding people from abuse; safe care and treatment and good governance and told them to take action to make the required improvements.
We also placed the service in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.

During this inspection in July and August 2017, the service demonstrated to us that improvements had been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The previous registered manager resigned in January 2017. An acting manager [manager] was in place at the home and they had applied to register with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

We found the manager had a good understanding of their responsibilities in relation to meeting the Health and Social Care Act 2008 regulations. They had notified us appropriately of events required by law. The manager and provider had understood the seriousness of the concerns we highlighted during our previous inspection and had worked closely with other agencies for support and advice in how to make the improvements required.

People and relatives told us they felt the home was safe. Staff had received additional safeguarding training, understood how to identify abuse and explained the action they would take if they identified any concerns about people's safety.

Individual and environmental risks relating to people's health and welfare had been reviewed to identify, assess and reduce those risks. Up to date guidance was available for staff in how to support people in line with the risk assessments. Incidents and accidents had been investigated and learning shared with staff to reduce the risk of re-occurrence.

Systems were in place to ensure the management and administration of medicines, including controlled drugs, were safe. Some minor issues were identified which the manager said they would address. Staff received training to administer medicines and were assessed for competency.

Robust recruitment processes ensured that only suitable staff were employed. There were sufficient staff deployed to meet people's needs during the day. Staff had time to sit and chat with people and support their emotional wellbeing. There were sufficient day staff deployed. However, night staffing roles did not reflect people's night time care needs.

People were supported by staff, most of whom had received appropriate training, professional development, supervision and appraisal to enable them to meet people's individual needs. Plans were in place to increase supervisions and appraisals for all staff.

The manager and staff understood and followed the principles of the Mental Capacity Act 2005 designed to protect people's rights and ensure decisions were made in their best interests.

People were supported to maintain their health and well-being and had access to healthcare services when they needed them.

People enjoyed a variety of freshly cooked foods, prepared in a way that met their dietary needs. People received the support they needed to eat their meals.

Staff treated people with dignity and respect and ensured their privacy and independence was promoted. Staff interactions with people were kind and caring. Staff provided reassurance when people became anxious or upset. Friends and family were able to visit their loved ones at any time and felt welcomed by staff.

A part time activities co-ordinator had been employed who organised and provided opportunities for people to engage in social and physical activities.

People had detailed care plans which were regularly reviewed and updated when people's needs changed. Some minor issues were identified which the manager told us they would address. People and their relatives, when appropriate, were involved in decisions about care planning.

Systems to monitor and assess the quality and safety within the home had improved. People and relatives were encouraged to provide feedback on the service provided through satisfaction surveys and informally during visits to the home.

Residents meetings took place and enabled people and family members to be kept up to date with improvements the provider was making. People and relatives confirmed they knew how to make a

complaint and would do so if they needed to.

A range of audits were in place to identify shortfalls in service delivery. However, actions were not always recorded to ensure they had been followed through.

Staff meetings took place and staff felt well supported by the manager who was open and approachable. Staff were confident to raise any issues or concerns with them and were listened to and respected.

We recommend the provider reviews their night staffing roles in line with current good practice to better reflect the care needs of people during the night.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines management had improved since our last inspection, although some medicines records required further improvement. Risks had been assessed and measures put in place to minimise risks although some records were conflicting. Night staffing roles did not reflect people's planned needs.

Staff followed safeguarding procedures to identify and protect people from abuse or improper treatment. Recruitment practices ensured that only staff who were suitable to work in social care were employed.

Fire safety checks were carried out and equipment was regularly serviced and maintained. The home was clean and tidy and staff were aware of infection prevention and control procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff received regular supervision and appraisal, although the manager was taking action to address this. Staff received induction and training. Staff told us they felt well supported in their roles and could seek advice and guidance when needed.

People's rights were protected because the manager and staff had a good understanding of the MCA 2005.

People were supported to have enough to eat and drink in a way that met their specific dietary needs. People had access to health professionals and other specialists when needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and dignity and respected people's wishes.

Staff had time for people, listened to them and encouraged their

independence.

Family members and friends were welcome to visit at any time and valued the calm, relaxed, family feel in the home.

Is the service responsive?

Good

The service was responsive.

People and their families were involved in planning their care. People's care plans focused on their individual needs, choices and preferences and were regularly reviewed.

A range of activities were available for people to participate in if they wished to do so.

An up to date complaints procedure was on display and relatives were confident any concerns would be addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Record keeping and monitoring of the quality of the service had improved significantly since our previous inspection, although there was still work to do to embed the systems and ensure these were being effective at driving on-going improvements.

The manager was taking action to seek people's and their relatives views about the home and quality of the service being provided.

Staff felt well supported by the registered manager who provided clear leadership and direction. The provider maintained oversight of the home and kept up to date with the improvements being made.

Moorland House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also needed to check the provider had made the improvements we told them to make during our inspection in December 2016 and to check they had met the four enforcement notices issued to them.

The inspection was unannounced and was carried out by a lead inspector and second inspector on 28 July 2017. The lead inspector returned on 31 July and 1 & 2 August 2017 to complete the inspection, which included two night visits.

Before the inspection, we reviewed all the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed progress on a number of safeguarding concerns raised at our previous inspection.

We spoke with three people living at the service and six relatives. We observed people being cared for and supported at various times in communal areas to help us understand the experience of people who could not speak with us. We spoke with six care staff, including two night staff, the activities co-ordinator, the administrator and the registered manager. Following the inspection we also received feedback about the service from two community health and social care professionals.

We looked at a range of documents including five people's care records, six medicine administration records (MARs) and six staff recruitment, supervision and training records. We also looked at other records related to the running of the home, such as complaints, incidents, accidents and audits monitoring the quality of the service provided.

The home was last inspected in December 2016 during which we found nine breaches of Regulations.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated this key question as inadequate. Improvements have been made, but some of these need to be embedded further and so we have now rated the domain as requires improvement.

People and their relatives told us they felt safe living at Moorland House. One relative told us, "I want [my family member] to be well fed, warm and safe, and she is." They went on to say, "There is nearly always someone in the lounge or office. You don't have to go far if you need someone." Another relative told us they were happy with how their family member was cared for and confirmed, "I have no concerns." Health and social care professionals, who had been involved in investigating safeguarding concerns raised after our previous inspection, confirmed to us they had seen improvements in the safety of care at Moorland House.

At our previous inspection we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014, safe care and treatment.

Risks associated with people's individual support needs such as falls, weight loss, skin integrity and moving and positioning, had not been appropriately identified and assessed to protect them from harm. At this inspection we found improvements had been made and the provider was now meeting the fundamental standards with regards to safe care and treatment. Risk assessments had been reviewed and re-written and were now fit for purpose. Our last inspection had identified concerns that risks associated with choking, behaviour that challenged, moving and positioning and people leaving the home unnoticed (absconding) had not been assessed and managed. These risk assessments were now in place. The manager had sought specialist support to assist them in assessing people's needs and risks when required. For example, an occupational therapist had assessed a person for their moving and positioning needs and their recommendations had been followed. Measures had been put in place to guide staff in how to minimise any risks and staff were aware of the actions they needed to take. Risk assessments were regularly reviewed and updated when required. For example, when a deprivation of liberty safeguard authorisation had been made for one person, this had been added to their 'absconding' risk assessment. Although significant improvements had been made, we noted that some people's care plans and corresponding risk assessment contained conflicting information. We discussed these issues with the manager who was responsive to the issues we raised and told us they would address them.

At our previous inspection we found that environmental risks had not been adequately identified and managed to protect people from harm. Significant improvements were found at this inspection. Maintenance issues had been addressed, such as fixing loose radiator covers to the wall and enclosing an exposed boiler and hot pipework. Environmental risks assessments had been completed in February 2017, however these had not yet been shared with staff. The manager confirmed they would ensure staff were made aware of these risks and the measures in place to reduce them.

At our previous inspection we found a number of unsafe practices in relation to the management of medicines, including controlled drugs (CDs). At this inspection we found new systems had been put in place to monitor the effectiveness and safety of medicines management and significant improvements had been

made. However, improvements were still needed to ensure that staff had adequate guidance and supporting information about the safe administration of people's medicines. For example, when one person's topical cream had been changed, this had been added to their Medicine administration record (MAR). However, the previous cream had not been removed or crossed through to show it was no longer in use. Another person's PRN (as and when required) medicine came in 30mg and 500mg tablets. The PRN protocol informed staff not to give more than eight tablets in twenty four hours. This was ambiguous and did not make clear what the maximum dose should be. Where medicines had been discontinued on people's MARs, it was not always clear who had authorised the changes. We discussed these issues with the manager who was responsive and told us they would address the issues we raised.

People received their medicines from staff who were appropriately trained and regularly re-assessed for their competency. People were asked for their consent before being given their medicines. They were encouraged to take their medicines and were given the time they needed to do so. We observed one person was eating their lunch and did not respond positively when asked if they wanted their medicine. The staff member said they would come back after they had finished eating. Staff clearly recorded on people's MARs when they had received their medicines. Additional signing sheets had been put in place for the recording of topical creams and anti-coagulant medicines which provided a double check for staff that these had been given.

Safe systems were in place for the ordering; storage and disposal of medicines, including Controlled Drugs. CDs are specific medicines which are managed under the Misuse of Drugs Act 1971. Medicines were ordered in a timely way and stocks were well controlled to ensure no excess medicines built up. Medicines, including CDs, were appropriately stored in accordance with their specific requirements. We checked the medicines cabinet in the dining room which we saw was secured and locked. A staff member had also checked the cabinet and told us, "We have learnt from our mistakes. It's what you do isn't it." Another member of staff confirmed the allocated staff member for medicines on each shift retained the key whilst on duty and we saw this to be the case. A spot check of CDs showed these were current, in date and the amount of stock corresponded with the CD register which two staff had signed each time CDs had been administered. Daily temperature checks took place to ensure medicines were stored in line with manufacturer's instructions and remained effective and safe to use. Spoilt or unwanted medicines were recorded and stored safely until they could be returned to the pharmacy. A social care professional told us they had visited the home in April 2017 and had found no concerns with medicines management.

At our previous inspection we found that staff had not always followed their falls protocol and people had not always received safe care and treatment following a fall. At this inspection we found that significant improvements had been made. People received appropriate care and treatment following a fall which included attendance from paramedics, obtaining telephone medical advice, observation and reassurance. The manager had worked closely with health professionals to identify and implement a system to review and learn from each incident of a fall. Following each fall, staff discussed what happened, could it have been prevented and any other action that was required, such as a referral to the falls team.

There were sufficient staff deployed during day time shifts to meet people's needs and keep them safe. We observed staff had time to sit and chat with people and responded to their requests for support in a timely way. For example, when call bells rang, staff promptly checked the call bell panel to see who was ringing for assistance and went to attend to them straight away. Staff confirmed there were usually enough staff on duty. They told us the paperwork was left for the seniors to do now which gave care staff more time to spend with people.

There were two night staff on duty each night between 8pm and 8am. One of these night staff members then

did a sleep-in shift between 12 midnight and 5am, leaving one waking night staff member to supervise the home. However, both night staff members were required to provide routine assistance to turn four people every two hours throughout the night as part of their planned care. We checked people's turn charts and noted that sleep-in staff were woken constantly, often every hour or more, throughout the five hours of their sleep-in shift. We spoke with two sleep-in night staff members who confirmed they were woken regularly each night during their sleep-in shift although they told us they didn't mind being woken up. However, this showed that a sleep-in staff member was not an effective deployment of staff. We discussed our concerns with the manager as it is not good practice to employ staff to provide sleep-in cover when people have planned, routine care needs that require attending to throughout the night.

We recommend the provider reviews their night staff cover to reflect the planned support needs of people during the night in line with good practice guidelines.

Only staff who were suitable to work with people in a social care setting were employed at the home. Disclosure and Barring Service (DBS) checks were in place for staff. DBS checks help employers to make safer recruitment decisions. Recruitment records for each staff member included proof of identity, an application form and a full employment history. Satisfactory references were sought before staff commenced work at the home.

At our previous inspection we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014, Safeguarding people from abuse and improper treatment. At this inspection we found the systems and processes for identifying and reporting abuse had improved and now met the requirements of this Regulation. Staff had received updated training in safeguarding adults and were able to identify the different types of abuse that could occur within the home. Safeguarding people from harm was discussed at staff meetings and care plans included information about how to report concerns to outside agencies. Staff understood their responsibilities for reporting any concerns to the manager and to the local authority safeguarding team and the Care Quality Commission (CQC). Staff were aware of the home's whistleblowing policy and told us they would use it if required. Whistleblowing is when staff report any concerns they have about staff practice within the home. A social care professional confirmed that any safeguarding concerns were now appropriately referred to them by the manager.

Regular servicing and maintenance of equipment took place, such as the hoists and portable appliances. Fire safety checks, such as alarm tests, firefighting equipment and emergency lighting checks also took place. Staff had completed recent fire safety training which included the use of equipment to assist people with limited mobility to evacuate. Each person had a personal evacuation plan, detailing the specific support they required to evacuate the building in the event of an emergency. The manager was not able to locate an up to date emergency contingency plan and told us they would discuss this with the provider.

The home was clean and tidy. A relative told us, "I went to the kitchen door and popped my head in. It was spotless!" Staff had completed recent training in infection prevention and control and were aware of infection control procedures in the home. Protective clothing was available and we observed this was used by staff.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated this key question as inadequate. Improvements have been made, but some of these need to be embedded further and so we have now rated the domain as requires improvement.

People and relatives told us that staff acted quickly to seek advice and assistance from medical professionals when required. One relative told us, "They're quick to call the GP if needed." Another relative told us their loved one was doing well, had put on weight and was sleeping much better. They said, "I haven't seen her looking so well and happy." People and relatives confirmed staff asked for consent before providing any care and support.

At our inspection in June 2016 we found the provider was in breach of Regulation 13 of the Health and Social Care act 2008 (regulated Activities) Regulations 2014 because they had not met the requirements of the Mental Capacity Act 2005. At this inspection we found improvements had been made and they now met the requirements of this Regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. Mental capacity assessments had been completed appropriately and best interest decisions made with the involvement of relevant others, such as relatives and GPs. Staff understood the principles of the MCA and had received recent training which was confirmed by a care professional who had been involved with the home.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). The manager understood their responsibilities in relation to DoLS and had applied for appropriate authorisations which had been assessed. Where conditions had been attached to a person's DoLS, the manager had acted on these and recorded the outcomes. Where relatives did not agree with conditions, the manager had requested a review by the DoLS assessor.

At our previous inspection we found the provider was in breach of Regulation 18 of the Health and Social Care act 2008 (regulated Activities) Regulations 2014 because they had not provided staff with regular supervision and appraisal. At this inspection we found improvements had been made and they now met the requirements of this Regulation, although some of these improvements needed to be embedded. Supervision provides staff with formal opportunities to discuss their work performance, any training needs, ideas or concerns. The manager had carried out a number of supervision meetings with staff; however, not all staff had received regular supervision. For example, three staff had not received a formal supervision since March 2017 and one staff member since February 2017. There were no records of supervision for four

staff, including a night staff member, housekeeping staff and the chef. Following our discussion, the manager put in place a schedule, prioritising those staff who were overdue their supervision. Not all staff who had been employed for a year or more had received an annual appraisal. The manager had started to complete staff appraisals during January and March 2017 and this was in progress. Although not all staff had received regular supervision, they told us they felt well supported and could ask for advice or guidance when they needed to.

Staff had received regular training opportunities to keep their knowledge up to date, such as fire safety, moving and handling and infection control. Specific training had been provided which helped to equip staff with the knowledge and skills to address some of the areas of concern found at our previous inspection. For example, training had been provided in principles of risk assessment, pressure area care, dementia awareness and behaviour management. New staff completed an induction that included working alongside experienced staff as well as completing the Care Certificate, where required. The Care Certificate is a nationally recognised set of induction standards which staff working in health and social must adhere to.

Staff were proactive in requesting visits or reviews from health professionals, such as GP's or district nurses, when they had concerns about people's health and wellbeing. For example, one person had been referred to their GP due to a possible infection. Actions and recommendations had been carried through and recorded. People also had access to a range of preventative health care, such as dentists, opticians and chiropodists. Staff recorded all contacts and visits from health professionals in people's care plans and followed up any appointments where required.

People were supported to eat and drink sufficiently for their needs. People's care plans reflected their food preferences, likes and dislikes and staff were aware of people's specific dietary needs. We observed the lunch meal and saw that food was prepared in a way which met people's specific needs, such as a pureed or soft diet. The lunch meal was served from the hot trolley in the dining room and staff welcomed everyone to the dining room with a smile and a description of the food choices for that meal. Alternative food choices were available if people did not want the main meal choice of the day. A health professional had recently supported the staff to implement the 'Hydrate project' which provided training to staff in how to ensure people remained hydrated. We saw that people were consistently offered drinks throughout the day and encouraged to drink. Where people required assistance to drink, this was given. Where people had not had much to drink during the morning, this information was passed to staff coming on shift in the afternoon.

People were referred for specialist support with their eating and drinking when required. A health professional told us about one person who had been seen by the speech and language team (SALT) who "Following observation are happy with the regime currently in place by the home."

Good

Is the service caring?

Our findings

People and relatives told us the staff at Moorland House were very kind and caring. One relative said, "I can't fault them. They always have a chat with [my family member]. It's relaxed and homely. It feels like a proper home." Other comments from relatives included, "Staff are lovely, patient, kind and caring" and "Staff are very nice and polite." One person told us they particularly liked one member of staff and said, "He's lovely. A nice smile. He looks at you when he smiles!" Another person spoke of another staff member and said, "He's a lovely lad. Everything he does, he always says 'You're welcome'."

At our previous inspection in December 2016 we observed that some staff did not always respect people's privacy and dignity. At this inspection we found all staff provided dignified care that ensured people's privacy. Staff spoke discretely when discussing people's needs to maintain their confidentiality and used appropriate language which was respectful and caring.

There was guidance for staff in people's care plans on how to maintain people's privacy and dignity when providing care. For example, how staff should manage people's continence needs to ensure their dignity was preserved. We observed other ways in which staff ensured people's privacy, for example, they knocked on doors and waited for a response before entering people's rooms and spoke quietly and discretely when talking to people in communal areas. A relative told us they were very happy with the dignified care their loved one received and said, "They would be out of here if I wasn't happy!" If they wished to do so, people could choose to spend time in their rooms and this was respected by staff. People had personalised bedrooms with their own belongings, such as photographs, pictures, soft furnishings, TVs and radios. One relative told us, "We had a phone installed and could bring her own belongings and furniture. It's lovely and clean and freshly decorated."

Staff had a very good knowledge of the people they supported and used people's preferred names where appropriate. The atmosphere in the home was calm and relaxed and we observed laughter and banter between staff, people and their relatives. Staff had time to sit with people and listened to what they had to say so they felt that they mattered. A relative told us, "They [staff] come and sit next to them for a chat and the cleaner sits with them in their tea break." Another relative said, "I can't fault them. They always have a chat." Staff confirmed they had more time to spend with people now. Comments from staff included, "We have more time with the residents. We were so busy [task focussed]. We feel more at ease" and "We are more relaxed. The residents are more relaxed."

People were encouraged by staff to maintain relationships with their relatives and friends. For example, one person's lifestyle and activities care plan stated "[Person] can use the home phone to speak to family and friends. One friend visits weekly. Their son telephones weekly." Visitors were not restricted and were welcomed and this was confirmed by relatives who told us, "I can visit at any time" and "There's no restriction on visiting" and "You get to know other visitors." When relatives arrived we saw they were greeted warmly by staff. Staff knew people's relatives well and it was clear from the positive interactions with relatives and the feedback we received that there was a good rapport with the staff.

We observed staff encouraged people to maintain their independence as much as possible. People's care plans documented the tasks they could manage independently and the tasks with which they required support. For example, one person was independent in some aspects of their personal care and this was recorded in their personal hygiene care plan which also recorded when they might require some prompting.

People were supported by staff to maintain their personal appearance and self-esteem. We observed people were clean and well dressed and wore jewellery and matching accessories. A relative confirmed this when they told us, "[My family member] always looks nice and clean. I'm quite happy to leave her here, leave her in good care." Another relative confirmed their family member was, "Always clean and well dressed."

Good

Is the service responsive?

Our findings

Relatives told us they were involved in the planning of their loved one's care. One relative told us, "[The manager] saw my mum and assessed her. She seemed really nice. I can't believe the change in my mum [since she moved here]. She doesn't spend all day in her room like she used to." Relatives told us they were kept informed of reviews and any changes to their loved ones care.

At our previous inspection in December 2016 we found that people did not always have detailed and current care plans in place and some guidance for staff in how to support people was conflicting. At this inspection we found significant improvements had been made.

People's support needs had been assessed before they came to live at the home. Assessments were detailed and included information about people's life histories, work, hobbies and likes and dislikes as well as their religious beliefs and communication. They also included care and support needs such as their mobility and personal care. These assessments had been developed into person centred care plans which gave clear information to staff on how to meet the needs of people in a person centred and individualised way. For example, one person's night care plan stated "Likes to be in bed between 8pm and 9pm. Likes to sleep late morning. Prefers main light off and bedside light on." People and their relatives were involved in planning their care. Care plans were reviewed every month and any changes to people's needs were shared with staff. We observed that staff had a very good understanding of people's needs and preferences and respected their wishes.

At our previous inspection we found there was little stimulation for people during the mornings when staff were busy supporting people to get washed and dressed. At this inspection we found improvements had been made. We also observed staff spending time with people on a one to one basis talking, looking at books and doing gentle exercise. A staff member told us "We are encouraged more to interact with residents. We have more time now."

People had access to a range of activities both within the home and in the community. We observed people dancing with staff and enjoying a throwing game which brought out their competitive spirit and we saw that visitors joined in too. People seemed to enjoy the interaction and there was much laughter and banter. The provider had recently employed a part time activities co-ordinator to support people with social and physical activities. The activities co-ordinator told us, "I try to make things fun and stimulating. I use different textures, colours, sounds. I brought in some ribbons. They [people] liked the swish and the movement. A few weeks ago I brought in some plants with different smells and colours. . .sensory." They told us the provider had booked them onto a course in September "to learn more about activities for people with dementia" which they were looking forward to. The provider had also joined the National Activity Provider's Association (NAPA) which provides information, advice and access to activity resources. Staff had made a scrap book in which they kept photographs of different events and activities that had taken place and this was accessible to people and visitors to look at if they wanted to. A relative told us, "[The activities co-ordinator] paints nails and does puzzles with them [people]. There's a bit more going on now."

The home had an updated complaints procedure which reflected the change of manager, and was given to people when they first moved into the home and was also displayed in the reception area of the home. There were two concerns logged in the complaints file. These had both been addressed and responded to in writing in a timely way and people were satisfied with the outcome. Relatives told us they did not have any complaints but felt confident they would be listened to and any concerns would be addressed.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we rated this key question as inadequate. Significant improvements have been made, but some of these need to be embedded further and so we have now rated the domain as requires improvement.

The manager was visible and provided support and leadership within the home. People and relatives knew who the manager was and told us they were approachable and available if they needed to discuss anything. A relative told us, "[The manager] is very good. Always helpful."

There had been some management changes in the home following our previous inspection when the previous manager left. The current manager had been promoted from their previous role of deputy manager and appointed to manage the home with the support of the provider and staff team. The manager told us, "We are working together to improve. It's the only way. I want everyone to be safe. Staff morale took a knock but we're building them up. There's still a lot of work to do but we're getting there. We have changed the whole culture of the place. I'm happy with the way things are progressing." The manager had sought advice and information from health and social care professionals to support the improvements in the home. The manager had started a level five nationally recognised vocational qualification in health and social care and was developing a better understanding of governance requirements.

At our inspection in December 2016 we found the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because they had not reported events and incidents to the Commission when required by law. At this inspection we found significant improvements had been made and the provider now met the requirements of this Regulation. The manager understood their responsibilities in relation to notifying the Commission of relevant events and incidents and had done so when required.

At our inspection in December 2016 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 because they had not maintained current and accurate records. At this inspection we found significant improvements had been made and they now met the requirements of this Regulation. People's care records had been reviewed and/or re-written to address the issues and concerns raised at our previous inspection. These were detailed and current and provided clear guidance for staff in how to support people. We did note that there was still some conflicting information in some people's care records which we discussed with the manager who told us they would address this.

At our inspection in December 2016 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 because they had not effectively monitored the quality and safety of the home. At this inspection we found significant improvements had been made and they now met the requirements of this Regulation. However, there was still work to do to ensure the processes were fully implemented and effective.

The provider had been responsive to the concerns we raised at our previous inspection and had attended a meeting with the Commission to discuss how they intended to make the improvements required. They had kept us informed about the progress they were making through updated action plans and by attendance at safeguarding meetings where they were open and transparent in what had gone wrong and what they were doing to put things right.

Arrangements were in place which enabled the provider to maintain oversight of the service and progress towards their action plan. The provider visited the service regularly to talk to people and staff. Monthly management meetings took place between the manager and the provider where they discussed, for example, staffing; maintenance; quality assurance and activities. They also discussed and reviewed how they were progressing against their service action plan. A weekly report was completed by the manager and sent to the provider. This included information about any incidents; DoLS submissions; maintenance and staffing. A consultant was employed to provide on-going advice and support, although this had reduced recently in line with the manager's growing knowledge and competence.

Systems were in place to enable people and relatives to give feedback about the care they received. Residents and relatives meetings took place and we noted the provider had attended to update them on the previous inspection report and the changes to management in the home. Following discussions with the manager, there were plans in place to seek peoples views about the quality of care provided and to check that they felt improvements had been made.

A range of audits were in place to monitor the quality of the service. For example, to check medicines management and care plans. This had provided the manager with valuable information about how the service had improved and where any shortfalls remained. However, it was not always clear what action had been taken as a result of their findings. There was still work to do to ensure audits were being fully effective at driving ongoing improvements.

Staff felt supported in their roles by the manager who was approachable and supportive and they consistently told us the home was more relaxed. One staff member told us, "[The manager] has stepped up to the mark. She knows what needs to be done. She consults. She's better at talking with staff. Everyone is on board." They went on to say, "[The manager] got it straight away. She was more than happy to embrace it." Another staff member said, "[The manager] is very supportive. There's more teamwork. She explains what to do next. Communication is better, who's doing what. She'll help out if we need her." A third staff member told us, "[The manager] is so calm. It's what I like about her. She doesn't get flustered; she just quietly gets on with it."

Staff told us communication had improved and the home was running more effectively. Weekly '10 @ 10' meetings took place, which was a ten minute meeting for staff to get together and discuss any issues with the manager. Monthly staff meetings took place which enabled staff to discuss ideas and issues in more detail and agree any actions to take. Minutes of recent meetings showed staff discussed for example, safeguarding; hydration; care plans and training. Staff told us they felt listened to and involved in developing the service.

Incidents and accidents had been recorded, investigated and analysed and any learning was shared with staff. The manager attended meetings held by other social care organisations when possible, which helped them keep up to date with any changes in legislation or good practice.